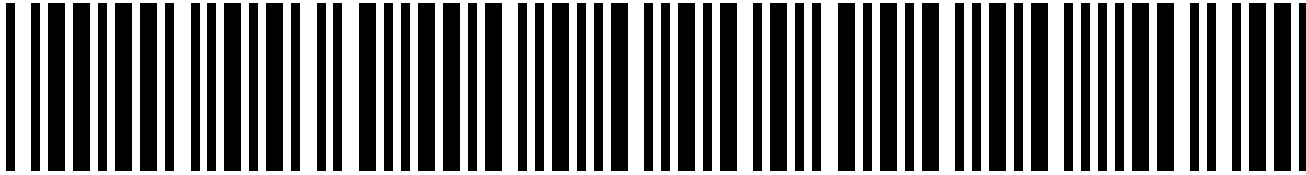


This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA  
DWC DISTRICT OFFICE  
DOCUMENT COVER SHEET



Is this a new case? Yes ☐ No ☒ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☒

More than 15 Companion Cases ☐

09/10/2008

Date:(MM/DD/YYYY)

SSN: 000-00-0000

ADJ12345

☒ Specific Injury

02/02/2004

Case Number 1

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

**Please check unit to be filed on ( check only one box )**

☒ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ VOC ☐ INT ☐ RSU

**Companion Cases**

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

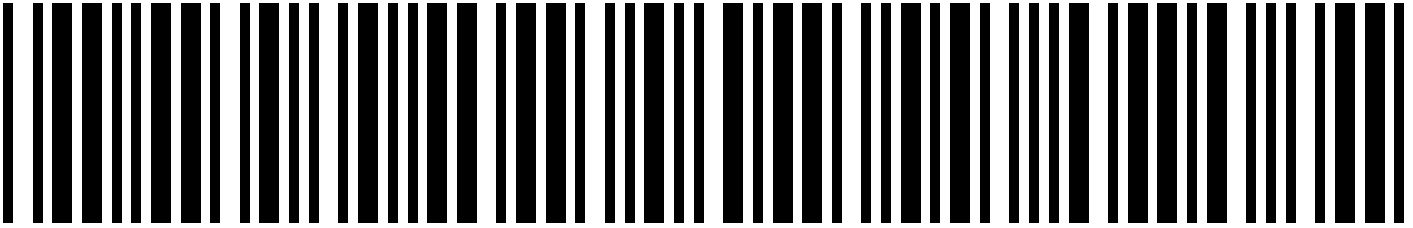
Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

# DOCUMENT SEPARATOR SHEET



Product Delivery Unit ADJ

Document Type LIENS AND BILLS

Document Title NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Date of document following  
Document Separator Sheet

Document Date MM/DD/YYYY

Author UNIFORM ASSIGNED NAME

If no Uniform Assigned Name,  
"Author" is name of person/entity  
filing the lien. Example:  
**JOHN A SMITH**  
**JOHN B SMITH MD**  
Use only capital letters and no  
special characters  
e.g. / \ ' . " , : ; ( ) & !

---

## Office Use Only

Received Date MM/DD/YYYY

STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Date Of Original Lien \_\_\_\_\_ ☐ Original Lien ☐ Amended Lien  
MM/DD/YYYY

CASE No. \_\_\_\_\_

(Choose only one)

☐ a Specific Injury on \_\_\_\_\_  
(DATE OF INJURY: MM/DD/YYYY)

☐ a Cumulative Injury which began on \_\_\_\_\_ and ended on \_\_\_\_\_  
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

SSN Numbers Only \_\_\_\_\_ (DATE OF BIRTH: MM/DD/YYYY)

Injured Worker

First name \_\_\_\_\_ MI \_\_\_\_\_

Last Name \_\_\_\_\_

Address/PO Box ( Please leave blank spaces between numbers , names or words) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Attorney/Representative for Injured Worker

Name \_\_\_\_\_

Address/PO Box ( Please leave blank spaces between numbers , names or words) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Lien Claimant (Completion of this section is required)

Organization \_\_\_\_\_

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Address/PO Box ( Please leave blank spaces between numbers, names or words) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

**Lien Claimant Attorney/Representative**

☐ Law Firm/Attorney ☐ Non Attorney Representative ☐ Lien Claimant not represented

Lien Claimant Law Firm/Representative

First Name

Last Name

Address/PO Box ( Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Phone

Employer

Name

Address/PO Box ( Please leave blank spaces between numbers, names or words)

City

State

Zip Code

**Insurance Carrier or Claims Administrator Information**

Name

Address/PO Box ( Please leave blank spaces between numbers, names or words)

City

State

Zip Code

**Employer or Claims Administrator Attorney/Representative (if known)**

Name

Address/PO Box ( Please leave blank spaces between numbers, names or words)

City

State

Zip Code

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of \$ \_\_\_\_\_ against any amount now due or which may hereafter become payable as \_\_\_\_\_ Total Lien Sum Amt compensation to the above named worker on account of the above claimed injury.

**This request and claim for lien is for (Mark appropriate box) :**

- ☐ A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- ☐ The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600.(Labor Code § 4903 (b).)
- ☐ Reasonable expense incurred by or on behalf of the injured medical-legal expenses (Labor Code § 4903 (b).)
- ☐ The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury.(Labor Code § 4903 (c).)
- ☐ The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- ☐ The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- ☐ The reasonable fee for interpreter's services performed on \_\_\_\_\_ 20 \_\_\_\_ . (Labor Code § 4600 (f).)
- ☐ The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- ☐ The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)
- ☐ Other Lien(s): Specify nature and statutory basis.

**NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED**

- ☐ a copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

\_\_\_\_\_  
(Signature of Attorney for Lien Claimant)

\_\_\_\_\_  
(Signature of Lien Claimant)

\_\_\_\_\_  
Date (MM/DD/YYYY)

# **Itemized Billing Statement**

# **Itemized Billing Statement**

# **Proof of Service**